



***Technical Expert Panel for the Clinical  
and Anatomic Pathology Measure  
Development Project***  
**Summary of  
Feedback on Measure 7**

**Feedback Submission Deadline: [06/05/2020](#)**

**Recorded By: [Liz Waibel and Raven Garris](#)**

## 1. Attendance

Not Applicable

*Feedback on Measure 7 was provided via email*

## TEP Roster

Name, Credentials, and Professional Role	Organizational Affiliation, City, State
<b>TEP MEMBERS</b>	
Diana Kremitske, MS, MHA, MT (ASCP), Vice President Diagnostic Medicine Institute	Geisinger Danville, PA
Lynnette Chakkaphak, MS, MT (ASCP), Director of Clinical Operations	Ascension St. Vincent's Jacksonville, Florida
Gary Procop, MD, FASCP, MS, Chair, Clinical Pathology	Cleveland Clinic Cleveland, OH
Scott Owens, MD, FASCP, Professor of Pathology	University of Michigan Ann Arbor, MI
Cecelia (Ceil) Duclon, MLS (ASCP) <sup>CM</sup> , MS, Executive Lab Director	Froedtert & Medical College of Wisconsin Greater Milwaukee Area, WI
Nils Diaz, MD, Medical Director	Mease Hospitals Baycare Health System Safety Harbor and Dunedin, FL
William Finn, MD, FASCP, Medical Director	Warde Medical Laboratory Ann Arbor, MI
Michelle Mitchell, Patient Advocate	University of Michigan Ann Arbor, MI
Greg Sossaman, MD, FASCP, Chairman, Department of Pathology and Laboratory Medicine	Ochsner Clinic Foundation New Orleans, Louisiana
Jonathan Genzen, MD, FASCP, Section Chief Clinical Chemistry, ARUP Laboratories & Associate Professor (Clin)	ARUP Laboratories University of Utah Salt Lake City, UT
Mary Ann Friedlander, MPA, CT(ASCP), Quality & Regulatory Manager - Department of Pathology	Memorial Sloan Kettering Cancer Center New York, NY
Joe Sirantrapin, MD, FASCP, FCAP, Director of Pathology Informatics	Memorial Sloan Kettering Cancer Center New York, New York
<b>ASCP STAFF</b>	
Jeff Jacobs, MA	ASCP Washington, D.C.
Ali Brown, MD, FASCP	ASCP Jackson, MS
Liz Waibel, MPH	ASCP Denver, CO
Amy Wendel-Spiczka, M.S., SCT, HTL, MB (ASCP) <sup>CM</sup>	ASCP Scottsdale, AZ
Raven Garris, MPH	ASCP Washington, D.C.
<b>IMPAQ STAFF</b>	
Maggie Lohnes	
Stacie Schilling	
Michelle Lefebvre	

## 2. TEP Purpose

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) Grant Technical Expert Panel (TEP) will guide the translation of seven pathology performance measures that incentivize value-based care both within laboratory medicine and among allied medical specialties.

The primary goals of the TEP are as follows:

- Goal 1: Reviewing measure specifications to ensure continued face validity and the intent of the measures remain intact; and recommending updates where appropriate.
- Goal 2: Reviewing measure business cases to ensure they reflect relevant clinical guidelines, systematic evidence reviews, and other sources of evidence to support measure focus; and recommending updates where appropriate.
- Goal 3: Conducting a feasibility assessment for the proposed MACRA measures as Electronic Clinical Quality Measures (eCQM). Initially, we will test two (of seven) measures for eCQM feasibility, and utilize lessons learned to test feasibility for the remaining five measures\*

## 3. Feedback Objective

- a. The objective of the request for feedback is to receive TEP input on the measure specifications for Measure 7: Rate of communicating results of an amended report with a major discrepancy to the responsible provider

## 5. Measure Concepts

- a. **Measure 1:** Notification to the ordering provider requesting myoglobin or CK-MB in the diagnosis of suspected acute myocardial infarction (AMI)
- b. **Measure 2:** Notification to the ordering provider requesting thyroid screening tests other than only a thyroid stimulating hormone (TSH) test in the initial screening of a patient with a suspected thyroid disorder
- c. **Measure 3:** Notification to the ordering provider requesting amylase testing in the diagnosis of suspected acute pancreatitis
- d. **Measure 4:** Time interval: critical value reporting for troponin
- e. **Measure 5:** Time interval: critical value reporting for chemistry
- f. **Measure 6:** Rate of notification to clinical provider of a new diagnosis of malignancy
- g. **Measure 7:** Rate of communicating results of an amended report with a major discrepancy to the responsible provider

The proposed quality-measure concepts focus on priority areas communicated by CMS, with an emphasis on diagnostic accuracy, care coordination, and overuse of diagnostic tests to target performance gaps where there is known variation in performance. These patient-centered proposed measures directly affect patient diagnoses by measuring outcomes or processes that impact the detection and prevention of chronic disease. We are proposing to retool seven measure concepts, all of which are directly relatable to equivalent high-priority CMS Meaningful Measures topic areas. Measures #1, #2, and #3 are directly related to the Meaningful

Measure areas of Affordable Care and Overuse Measures; Measures #4 and #5 relate to Preventable Healthcare Harm; and Measures #6 and #7 relate to Healthy Living/Population Health and Prevention, Detection/Prevention of Chronic Disease.

*\*Note: As of March 2020, Measures 1-3 are removed from the project scope*

## 6. Agenda

- Not Applicable – feedback was provided via email and will be discussed during our next TEP meeting

## 7. TEP Recommendations on the candidate measure (Measure 7)

- Denominator Clarification:
  - Need to clarify what the denominator is. Is the denominator only focused on if the corrected report is called in less than five days? Is the denominator all corrected reports? Five days seems too lengthy for a report to be corrected.
- Definition Clarification:
  - Similar to the concern raised for Measure 6, the “responsible provider” may not be same provider who submitted the specimen to the laboratory. The identification of the treating physician may occur after the cancer diagnosis is reported, and thus not captured in the LIS at the time of specimen submission/accessioning. A process would be needed by lab to ensure communication to the right person as well as reliable and capture-able documentation of this.
  - Need to provide clarification or guidance on what constitutes a "major diagnostic discrepancy."
- Inclusivity:
  - Similar to the concern raised for Measure 6, remove "anatomic" from the measure indicators given that the measure should be inclusive of all pathology specialties, not just anatomic pathology.
- “Major” vs “Minor” Diagnostic Discrepancies:
  - Do LIS systems distinguish between amended reports issued for “major” diagnostic discrepancies vs “minor” diagnostic discrepancies such that extraction of data for Measure 7 can be done easily? LIS procedural steps for processing “corrections” to reports may be the same, but hopefully there is a method for institutions to easily parse out the relevant “major diagnostic discrepancy” cases (vs corrected reports processed for other types of amended reports i.e. “minor” discrepancy cases).
- Difference in communication methods for amended results
  - Method of obtaining this data point may be challenging if there are different communication methods for amended reports:
    - For example, communication of amended report via verbal conversation with provider vs documentation using discrete data field; if documentation of amendment communication is embedded as free text within a surgical pathology test report, this would be difficult to capture.

